

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0043653</u></p> <p>Facility Name: <u>ROSICLARE HEALTHCARE CENTER</u></p> <p>Address: <u>ROUTE 1 BOX 55A</u> <u>ROSICLARE</u> <u>62982</u> Number City Zip Code</p> <p>County: <u>HARDIN</u></p> <p>Telephone Number: <u>(618) 285-3655</u> Fax # <u>(618) 285-6667</u></p> <p>IDPA ID Number: <u>830320180027</u></p> <p>Date of Initial License for Current Owners: <u>02/07/98</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>JEFFREY E. BOLAND</u> Telephone Number: <u>(717) 213-3125</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1165 678 1297 824"> Officer or Administrator of Provider </td> <td data-bbox="1297 678 1948 824"> (Signed) _____ (Date) _____ (Type or Print Name) <u>LARRY BONDS</u> (Title) <u>PRESIDENT</u> </td> </tr> <tr> <td data-bbox="1165 824 1297 1036"> Paid Preparer </td> <td data-bbox="1297 824 1948 1036"> (Signed) _____ (Date) _____ (Print Name and Title) <u>JEFFREY E. BOLAND, DIRECTOR</u> (Firm Name & Address) <u>ZA CONSULTING</u> <u>305 NORTH FRONT STREET, HARRISBURG, PA 17101</u> (Telephone) <u>(717) 213-3125</u> Fax # <u>(717) 233-4633</u> </td> </tr> </table> <p align="center"> MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>LARRY BONDS</u> (Title) <u>PRESIDENT</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>JEFFREY E. BOLAND, DIRECTOR</u> (Firm Name & Address) <u>ZA CONSULTING</u> <u>305 NORTH FRONT STREET, HARRISBURG, PA 17101</u> (Telephone) <u>(717) 213-3125</u> Fax # <u>(717) 233-4633</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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Facility Name & ID Number ROSICLARE HEALTHCARE CENTER# 0043653 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>62</u>	Skilled (SNF)	<u>62</u>	<u>22,692</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>62</u>	TOTALS	<u>62</u>	<u>22,692</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>15,903</u>	<u>3,117</u>	<u>1,614</u>	<u>20,634</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,903</u>	<u>3,117</u>	<u>1,614</u>	<u>20,634</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 90.93%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 2/7/98

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 2/7/98 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 20 and days of care provided 1,614Medicare Intermediary TRAILBLAZER HEALTH ENTERPRISES, LLC

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number ROSICLARE HEALTHCARE CENTER # 0043653 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	75,608	5,312	3,063	83,983		83,983		83,983		1
2	Food Purchase		105,432		105,432		105,432		105,432		2
3	Housekeeping	48,321	7,452	87	55,860		55,860		55,860		3
4	Laundry	15,699	8,467	53,644	77,810		77,810		77,810		4
5	Heat and Other Utilities			51,555	51,555		51,555		51,555		5
6	Maintenance	25,308	9,517	25,162	59,987		59,987		59,987		6
7	Other (specify):*										7
8	TOTAL General Services	164,936	136,180	133,511	434,627		434,627		434,627		8
	B. Health Care and Programs										
9	Medical Director			4,000	4,000		4,000		4,000		9
10	Nursing and Medical Records	518,250	60,077	45,997	624,324		624,324	3,745	628,069		10
10a	Therapy		731	162,606	163,337		163,337		163,337		10a
11	Activities	18,186	2,082	3,914	24,182		24,182		24,182		11
12	Social Services	22,705		1,930	24,635		24,635	45	24,680		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	559,141	62,890	218,447	840,478		840,478	3,790	844,268		16
	C. General Administration										
17	Administrative			75,859	75,859		75,859	13,249	89,108		17
18	Directors Fees										18
19	Professional Services							26,629	26,629		19
20	Dues, Fees, Subscriptions & Promotions			8,667	8,667		8,667	(178)	8,489		20
21	Clerical & General Office Expenses	7,209	9,273	23,990	40,472		40,472	32,968	73,440		21
22	Employee Benefits & Payroll Taxes			101,332	101,332		101,332	58,071	159,403		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,564	3,564		3,564	2,933	6,497		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			23,301	23,301		23,301	17,729	41,030		26
27	Other (specify):*										27
28	TOTAL General Administration	7,209	9,273	236,713	253,195		253,195	151,401	404,596		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	731,286	208,343	588,671	1,528,300		1,528,300	155,191	1,683,491		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			59,730	59,730		59,730		59,730			30
31	Amortization of Pre-Op. & Org.			3,359	3,359		3,359	(115)	3,244			31
32	Interest			136,500	136,500		136,500		136,500			32
33	Real Estate Taxes			2,554	2,554		2,554		2,554			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			15,022	15,022		15,022		15,022			35
36	Other (specify):* Mort. Guarantee			20,181	20,181		20,181		20,181			36
37	TOTAL Ownership			237,346	237,346		237,346	(115)	237,231			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		5,530	29,218	34,748		34,748		34,748			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,038	34,038		34,038		34,038			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		5,530	63,256	68,786		68,786		68,786			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	731,286	213,873	889,273	1,834,432		1,834,432	155,076	1,989,508			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer- ence	OHF USE ONLY	
NON-ALLOWABLE EXPENSES				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals				4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties	(428)	21		18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional	(178)	20		25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule See Attached	(8,421)	Var.		29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (9,027)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	164,103	Var.	34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 164,103		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ 155,076		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
 (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		X	\$		38
39					39
40 Gift and Coffee Shops		X			40
41 Barber and Beauty Shops		X			41
42 Laboratory and Radiology		X			42
43 Prescription Drugs		X			43
44 Exceptional Care Program		X			44
45 Other-Attach Schedule		X			45
46 Other-Attach Schedule		X			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
ROSICLARE HEALTHCARE CENTER

Page 5A

ID# 0043653
Report Period Beginning: 01/01/00
Ending: 12/31/00

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Other Revenue	\$ (1,220)	21	1
2	Bank Charges	(55)	21	2
3	Prior Year Expense	(1,780)	21	3
4	Extraordinary Items	(5,000)	21	4
5	Amortization-Goodwill	(115)	31	5
6	Business Meals	(251)	21	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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84				84
85				85
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87				87
88				88
89				89
90	Total	(8,421)		90

Summary A

12/31/00

[illegible]

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ROSICLARE HEALTHCARE CENTER# 0043653

Report Period Beginning:

01/01/00

Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	(115)	0	0	0	0	0	0	0	0	0	0	(115)	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(115)	0	0	0	0	0	0	0	0	0	0	(115)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(9,027)	21,631	142,472	0	0	0	0	0	0	0	0	155,076	45

Facility Name & ID Number **ROSICLARE HEALTHCARE CENTER** # **0043653** Report Period Beginning: **01/01/00** Ending: **12/31/00**

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached List		See Attached List		Eden & Associates, Inc	Wilson, WY	Consulting

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	10 Contract Services - RN	\$	Senior Living Properties, LLC	100.00%	\$ 398	\$ 398 1
2	V	10 Contract Services - RN		Senior Living Properties, LLC	100.00%	1,530	1,530 2
3	V	10 Contract Services - RN		Senior Living Properties, LLC	100.00%	1,817	1,817 3
4	V	12 Social Services Consultant	1,930	Senior Living Properties, LLC	100.00%	1,975	45 4
5	V	17 Contract Services - Business Office	20,483	Senior Living Properties, LLC	100.00%	29,190	8,707 5
6	V	17 Contract Services - Administrator	55,776	Senior Living Properties, LLC	100.00%	60,318	4,542 6
7	V	24 Travel	2,479	Senior Living Properties, LLC	100.00%	5,276	2,797 7
8	V	21 Business Meals		Senior Living Properties, LLC	100.00%	251	251 8
9	V	24 Seminars		Senior Living Properties, LLC	100.00%	136	136 9
10	V	21 Office Supplies	4,321	Senior Living Properties, LLC	100.00%	4,693	372 10
11	V	21 Supplies	2,242	Senior Living Properties, LLC	100.00%	2,314	72 11
12	V	21 Postage	1,343	Senior Living Properties, LLC	100.00%	1,356	13 12
13	V	21 Telephone	13,044	Senior Living Properties, LLC	100.00%	13,995	951 13
14	Total		\$ 101,618			\$ 123,249	\$ * 21,631 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ROSICLARE HEALTHCARE CENTER

0043653

Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21 EDP Services	\$	Senior Living Properties, LLC	100.00%	\$ 4,217	\$ 4,217	15
16	V	19 Legal Fees		Senior Living Properties, LLC	100.00%	9,228	9,228	16
17	V	19 Accounting Fees		Senior Living Properties, LLC	100.00%	17,401	17,401	17
18	V	26 Insurance - General Liability	20,844	Senior Living Properties, LLC	100.00%	23,991	3,147	18
19	V	26 Insurance - Property & Contents	2,307	Senior Living Properties, LLC	100.00%	16,759	14,452	19
20	V	26 Insurance - Other	150	Senior Living Properties, LLC	100.00%	280	130	20
21	V	22 Workers Compensation Claims	41,104	Senior Living Properties, LLC	100.00%	85,370	44,266	21
22	V	22 Health & Dental Insurance		Senior Living Properties, LLC	100.00%	13,805	13,805	22
23	V	21 Management Fees		Senior Living Properties, LLC	100.00%	35,825	35,825	23
24	V	21 Overnight Shipping	2,672	Senior Living Properties, LLC	100.00%	2,673	1	24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 67,077			\$ 209,549	\$ * 142,472	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ROSICLARE HEALTHCARE CENTER # 0043653 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ROSICLARE HEALTHCARE CENTER # 0043653 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Senior Living Properties, LLC
 Street Address 3395 North Pines Drive, Suite 102
 City / State / Zip Code Wilson, Wyoming 83014
 Phone Number (307) 739-1209
 Fax Number (307) 739-1217

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Contract Services - RN	Resident Days (IL Only)	675,434	31	\$ 13,034	\$	20,634	\$ 398	1
2	10	Contract Services - RN	Resident Days (IL Only)	675,434	31	50,078		20,634	1,530	2
3	10	Contract Services - RN	Resident Days (IL Only)	675,434	31	59,476		20,634	1,817	3
4	12	Social Services Consultant	Resident Days (IL Only)	675,434	31	1,475		20,634	45	4
5	17	Contract Services - Business Office	Resident Days (Total)	1,728,555	88	729,382		20,634	8,707	5
6	17	Contract Services - Administrator	Resident Days (IL Only)	675,434	31	148,670		20,634	4,542	6
7	24	Travel	Resident Days (IL Only)	675,434	31	91,552		20,634	2,797	7
8	21	Business Meals	Resident Days (IL Only)	675,434	31	8,225		20,634	251	8
9	24	Seminars	Resident Days (IL Only)	675,434	31	4,452		20,634	136	9
10	21	Office Supplies	Resident Days (IL Only)	675,434	31	12,185		20,634	372	10
11	21	Supplies	Resident Days (IL Only)	675,434	31	2,350		20,634	72	11
12	21	Postage	Resident Days (IL Only)	675,434	31	440		20,634	13	12
13	21	Telephone	Resident Days (IL Only)	675,434	31	31,125		20,634	951	13
14	21	EDP Services	Resident Days (IL Only)	675,434	31	138,040		20,634	4,217	14
15	19	Legal Fees	Resident Days (Total)	1,728,555	88	737,379		20,634	8,802	15
16	19	Accounting Fees	Resident Days (Total)	1,728,555	88	1,457,713		20,634	17,401	16
17	26	Insurance - General Liability	Resident Days (Total)	1,728,555	88	263,635		20,634	3,147	17
18	26	Insurance - Property & Contents	Resident Days (Total)	1,728,555	88	1,210,642		20,634	14,452	18
19	26	Insurance - Other	Resident Days (Total)	1,728,555	88	10,924		20,634	130	19
20	22	Workers Compensation Claims	Resident Days (Total)	1,728,555	88	330,015		20,634	3,939	20
21	22	Health & Dental Insurance	Resident Days (Total)	1,728,555	88	1,156,469		20,634	13,805	21
22	21	Management Fees	Resident Days (Total)	1,728,555	88	1,721,509		20,634	20,550	22
23	19	Legal Fees	Resident Days (IL Only)	675,434	31	13,948		20,634	426	23
24	21	Management Fees	Resident Days (IL Only)	675,434	31	500,000		20,634	15,275	24
25	TOTALS					\$ 8,692,718	\$		\$ 123,775	25

Facility Name & ID Number ROSICLARE HEALTHCARE CENTER # 0043653 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Senior Living Properties, LLC
 Street Address 3395 North Pines Drive, Suite 102
 City / State / Zip Code Wilson Wyoming 83014
 Phone Number (307) 739-1209
 Fax Number (307) 739-1217

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Workers Compensation Claims	Resident Days (IL Only)	675,434	31	\$ 1,320,062	\$	20,634	\$ 40,327	1
2	21	Overnight Shipping	Resident Days (IL Only)	675,434	31	26		20,634	1	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,320,088	\$		\$ 40,328	25

Facility Name & ID Number **ROSICLARE HEALTHCARE CENTER**# **0043653**

Report Period Beginning:

01/01/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE****A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	GMAC Comm. Mortg. Corp.		X	Acquisition	\$8,081.00	02/06/98	\$ 1,161,640	\$ 1,087,424	02/01/08	0.0681	\$ 74,732	1	
2	CCS Note		X	Acquisition	\$300.00	02/06/98	51,400	51,400	02/06/08	0.0700	7,551	2	
3	See Attached		X	Acquisition	\$300.00	02/06/98	51,400	51,400	02/06/08	0.0700	7,551	3	
4												4	
5												5	
	Working Capital												
6	Health Care Financial Partners		X	Working Capital	None	02/06/98	41,875	21,833	Demand	Prime + 2%	46,666	6	
7												7	
8												8	
9	TOTAL Facility Related				\$8,681.00		\$ 1,306,315	\$ 1,212,057			\$ 136,500	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 1,306,315	\$ 1,212,057			\$ 136,500	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **ROSICLARE HEALTHCARE CENTER**# **0043653**

Report Period Beginning:

01/01/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	1,825	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	2,554	2
3. Under or (over) accrual (line 2 minus line 1).	\$	729	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	1,825	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$0 For 19 2000 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	2,554	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	2,690	8
	1996	2,556	9
	1997	2,638	10
	1998	2,584	11
	1999	2,554	12

	FOR OFF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 1999 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

X. BUILDING AND GENERAL INFORMATION:

A.
Square Feet:
12,600

B. General Construction Type:

Exterior
Masonry

Frame
Metal

Number of Stories
1

C.
Does the Operating Entity?

☒
(a) Own the Facility

☐
(b) Rent from a Related Organization.

☐
(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D.
Does the Operating Entity?

☒
(a) Own the Equipment

☐
(b) Rent equipment from a Related Organization.

☐
(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E.
List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F.
Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐
YES

☒
NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	304,920	1998	\$ 25,000	1
2					2
3	TOTALS	304,920		\$ 25,000	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	62		1998	1975	\$ 1,057,825	\$ 35,261	30	\$ 35,261	\$	\$ 102,844	4
5											5
6											6
7											7
8											8
9	Improvement Type**										9
10	Signage		1998		464	46	10	46		120	10
11	Air Compressor		1999		713	48	15	48		95	11
12	Floor Base		1999		747	75	10	75		137	12
13	Door Guards		1999		2,125	213	10	213		390	13
14	Rooftop A/C Unit		1999		3,676	735	5	735		1,348	14
15	Replace Electric Box		1999		806	40	20	40		74	15
16	Drapes/Tracks		1999		13,764	1,376	10	1,376		2,523	16
17	Door Alarm System		1999		3,170	317	10	317		449	17
18											18
19	Nurse's Station-In:0253000759		2000		1,713	38	15	38		38	19
20	Nurse's Station-In:31996		2000		1,302	29	15	29		29	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 1,086,305	\$ 38,178		\$ 38,178	\$	\$ 108,047	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 145,838	\$ 20,995	\$ 20,995	\$	Various	\$ 57,597	37
38	Current Year Purchases	7,799	557	557		Various	557	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 153,637	\$ 21,552	\$ 21,552	\$		\$ 58,154	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 1,264,942	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 59,730	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 59,730	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 166,201	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **Not Applicable**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: **Not Applicable** *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ **3,032** Description: **Dishwasher (\$196), Scaffolding (\$789), Copier (\$2047)**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			Not Applicable		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$

13. /2002 \$

14. /2003 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.3	# of prescripts			8,341	12,867		21,208	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Ancillary Services	39.2, 39.3					13,540		13,540	13
14	TOTAL			\$		\$ 8,341	\$ 26,407		\$ 34,748	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,000	\$	1
2	Cash-Patient Deposits	20,276		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,476)	189,295		3
4	Supply Inventory (priced at Cost)	11,526		4
5	Short-Term Investments			5
6	Prepaid Insurance	(15,471)		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 208,626	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000		13
14	Buildings, at Historical Cost	1,085,842		14
15	Leasehold Improvements, at Historical Cost	464		15
16	Equipment, at Historical Cost	153,636		16
17	Accumulated Depreciation (book methods)	(166,201)		17
18	Deferred Charges	23,304		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,122,045	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,330,671	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 458,181	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,276		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,825		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Intercompany SLP Texas	(103,161)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 377,121	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,212,057		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,212,057	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,589,178	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (258,506)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,330,672	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 20,660	1
2	Restatements (describe):		2
3	Audit Adjustments	48,894	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 69,554	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(328,060)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (328,060)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (258,506)	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Page 19

Facility Name & ID Number ROSICLARE HEALTHCARE CENTER

0043653

Report Period Beginning: 01/01/00

Ending:

12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,707,352	1
2	Discounts and Allowances for all Levels	(442,902)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,264,450	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	144,283	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 144,283	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	(394)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	50,672	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	26,967	19
20	Radiology and X-Ray	1,684	20
21	Other Medical Services	17,490	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 96,419	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	1,220	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,220	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,506,372	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	434,627	31
32	Health Care	840,478	32
33	General Administration	253,195	33
B. Capital Expense			
34	Ownership	237,346	34
C. Ancillary Expense			
35	Special Cost Centers	34,748	35
36	Provider Participation Fee	34,038	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,834,432	40
41	Income before Income Taxes (line 30 minus line 40)**	(328,060)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (328,060)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Extended If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number ROSICLARE HEALTHCARE CENTER

0043653

Report Period Beginning: 01/01/00

Ending:

12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing		\$	\$	1
2	Assistant Director of Nursing				2
3	Registered Nurses	7,794	128,042	14.08	3
4	Licensed Practical Nurses	11,097	110,389	8.53	4
5	Nurse Aides & Orderlies	26,747	199,327	6.39	5
6	Nurse Aide Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	1,696	18,186	9.19	9
10	Activity Assistants				10
11	Social Service Workers	3,583	22,705	5.43	11
12	Dietician				12
13	Food Service Supervisor	2,020	15,060	6.39	13
14	Head Cook	6,772	45,589	5.77	14
15	Cook Helpers/Assistants	363	14,959	35.28	15
16	Dishwashers				16
17	Maintenance Workers	1,905	25,308	11.38	17
18	Housekeepers	8,071	48,321	5.13	18
19	Laundry	4,855	15,699	2.77	19
20	Administrator				20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	931	7,209	6.64	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records	1,850	14,719	6.82	31
32	Other Health Care(specify)				32
33	Other(specify) <u>Nursing Admin.</u>	6,188	65,773	9.11	33
34	TOTAL (lines 1 - 33)	83,872	97,852	\$ 731,286 *	\$ 7.47 34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly 3,051	1.3	35
36	Medical Director	Monthly 4,000	9.3	36
37	Medical Records Consultant	Monthly 240	10.3	37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant	Monthly 138,733	10(a).3	40
41	Occupational Therapy Consultant	Monthly 19,791	10(a).3	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	Monthly 4,082	10(a).3	43
44	Activity Consultant	Monthly 3,914	11.3	44
45	Social Service Consultant	Monthly 1,930	12.3	45
46	Other(specify) <u>Utilization Review</u>	Monthly 840	10.3	46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 176,581		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Description	Amount
			\$	Workers' Compensation Insurance	\$ 85,370	IDPH License Fee	\$
				Unemployment Compensation Insurance	9,885	Advertising: Employee Recruitment	8,089
				FICA Taxes	50,343	Health Care Worker Background Check (Indicate # of checks performed)	
				Employee Health Insurance	13,805	Prof. Dues/Licenses	400
				Employee Meals		Advertising/Public Relations	178
				Illinois Municipal Retirement Fund (IMRF)*			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$				
B. Administrative - Other							
Description			Amount				
Contract Service-Business Office Manager			\$ 20,483			Less: Public Relations Expense	(178)
Contract Service-Administrator			55,376			Non-allowable advertising	(
						Yellow page advertising	(
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 75,859	TOTAL (agree to Schedule V, line 22, col.8)	\$ 159,403	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 8,489
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Description	Amount
			\$			Out-of-State Travel	\$
						In-State Travel	6,361
						Seminar Expense	136
						Entertainment Expense	(
						TOTAL (agree to Sch. V, line 24, col. 8)	\$ 6,497
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$	TOTAL	\$		

*** Attach copy of IMRF notifications**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number **ROSICLARE HEALTHCARE CENTER**

STATE OF ILLINOIS

0043653

Report Period Beginning:

01/01/00

Ending:

Page 23

12/31/00

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 32,354 Line 10.3
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 34,038
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? NO Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? Immaterial
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? NO - MINOR
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.